

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/08/2026
NAME OF PROVIDER OR SUPPLIER  Prairie Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE  16000 South Wabash South Holland, IL 60473	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure timely assessment and implementation of preventative measures to prevent the development of a pressure ulcer for one (R1) of three residents reviewed for pressure ulcers. This failure resulted in R1 developing a facility-acquired Stage 3 pressure ulcer to the coccyx. Findings include: R1 is a [AGE] year-old resident admitted to the facility on [DATE] to 11/13/25 with diagnoses including but not limited to: atrial fibrillation, seizure, hypertension, cerebrovascular accident, obesity, depression, cognitive and communication deficit, dementia, cerebral amyloid angiopathy, anxiety, history of encephalopathy, and coronary artery disease. R1's (MDS) Minimal Data Set assessment of 10/13/2025, section C, the BIMS (Brief Interviewed Mental Status) score was 03/15 (severely impaired cognition). MDS of 10/13/2025, GG section R1 is dependent on self-care- Helper does all the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. R1 is dependent on mobility assistance and requires roll left and right, sit to lying tub/shower transfer: The ability to get in and out of a tub/shower. R1 requires helper does all of the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. On 2/7/2025 at 1:45 PM, V4 (Wound Care Nurse) said, (R1) had no wound impairment on admission and stage 2 on the coccyx area was noted on 10/31/2025. We have shower sheets and skin alteration sheets for the nursing assistants to fill out when they observe any skin impairment. The floor nurse will notify the physician and obtain orders if I am not in the building. I will add the resident to the wound physician for the weekly rounds and do the treatment for the residents when I am in the building. The nurses are expected to do treatment if I am not in the building. The surveyor requested shower sheets, skin impairment sheets, and nursing routine skin assessment but V4 said, the facility does not keep shower sheets or skin impairment sheets past a month per facility policy. V4 said, I assessed (R1) on 10/31/2025, called the physician, and added the air mattress, dietary supplements, and added (R1) to the list of the wound physician rounds. R1's physician's order dated 10/03/2025 reads in part, Skin assessment weekly on shower or bath day. Per record review: 10/3/25: admission, intact skin 10/3-10/31: no documented weekly assessments 10/31/25: Stage 2 identified 11/11/25: Stage 3 documented Record review of 11/11/2025 V5 (Wound Care Physician) progress notes noted a stage 3 pressure ulcer to the sacrum measuring 4 x 5.5 x 0.1 cm with light sero-sanguinous drainage and fair healing potential and estimated time to heal 4 - 6 Months. On 2/7/2026 at 3:53 PM, V2 (Director of Nursing) said, nurses are expected to complete the skin assessment, check the shower skin assessment, and any skin impairment to be assessed, call the physician, and obtain orders. V2 stated, We have a wound care nurse who will complete the assessment and treatment. I cannot put a timeframe on when a wound will develop and turn into stage 2. I expected the nurses to turn, reposition, and keep residents dry and clean, and monitor the skin. Also, we take into consideration nutrition and</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  145927	Facility ID:  If continuation sheet Page 1 of 3

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F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p>keep residents hydrated. The surveyor requested skin assessments, shower sheets, and only received the skin assessment from admission on [DATE] and 10/31/2025, when R1 already had a stage 2 pressure ulcer to the coccyx area. V2 said the facility does not keep records of showers past the current month or the entire last month. V2 and V3 (Director of Clinical Service) both reviewed records for routine skin assessment under the electronic medical records with the surveyor, but none were found. V3 said skin assessments are expected to be added under the MAR (Medication Administration Records) for the nurses to complete. When questioned about how frequently V3 said per standard of care, on admission, and weekly for 4 weeks. During the records review with V2 and V3 of the MAR, no skin assessments were found as per the physician's order. Care plan and interventions updated on 10/31/2025 reads, skin will be checked during routine care on a daily basis, and during the weekly and biweekly bath or shower schedule. No additional assessments were provided by the facility at the time of this survey. In the absence of documentation, the facility failed to demonstrate that required skin assessments were completed or that the pressure ulcer was unavoidable in accordance with professional standards of practice and facility policy. On 2/7/2026 at 4:47 PM, V1(Administrator) provided the facility policy titled Pressure Injury and Skin Condition Assessment Policy dated 9/2016, reads:Purpose:To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure ulcers, assuring interventions are implemented.Standards:2-Residents identified by the Braden scale of being at high risk of skin breakdown will have a weekly skin assessment x4 by a licensed nurse.4-Each resident will be observed for skin breakdown daily during care on assigned bath day by the CNA (Certified Nursing Assistant). Changes shall be promptly reported to the charge nurse, who will perform the initial assessment.Wound Care Skin Inspection TableBath twice weekly or as necessary. Avoid hot water; use a mild cleansing agent that minimizes irritation and dryness of the skin. During the cleaning process, care should be taken to minimize the force and friction applied to the skin.Documentation of weekly head-to-toe assessment by the licensed nurse in the resident's chart or on the facility-approved form.Daily head-to-toe skin assessment by caregivers.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to maintain complete and accurate clinical records by not retaining skin assessment and skin monitoring documentation necessary to demonstrate compliance with physician orders as part of the resident's medical record. This failure applied to one (R1) of three residents reviewed for medical records. Findings include: R1 was admitted to the facility on [DATE]. A physician's order dated 10/03/2025 required weekly skin assessments on shower or bath day. Facility policy titled Pressure Injury and Skin Condition Assessment Policy dated 9/2016 required: Weekly head-to-toe skin assessments by a licensed nurse for residents at high risk; Daily observation for skin breakdown by certified nursing assistants; Documentation of skin assessments in the resident's medical record or on facility-approved forms. On 2/7/2026 at 1:45 PM, V4 (Wound Care Nurse) stated the facility utilized shower sheets and skin alteration sheets completed by nursing assistants to document skin observations. When requested to provide these records for R1, V4 stated the facility does not retain shower sheets or skin alteration sheets beyond one month per facility policy. On 2/7/2026 at 3:53 PM, V2 (Director of Nursing) confirmed the facility does not keep shower or skin assessment documentation beyond the current or previous month. V2 stated nurses are expected to complete skin assessments and monitor skin condition; however, when requested, the facility was only able to produce skin assessments dated 10/03/2025 (admission) and 10/31/2025 (after skin breakdown was identified). During record review conducted with V2 (Director of Nursing) and V3 (Director of Clinical Services), the surveyor was unable to locate documentation of routine weekly or daily skin assessments in the electronic medical record. V3 stated skin assessments were expected to be documented on the Medication Administration Record (MAR); however, review of the MAR revealed no documented skin assessments as required by physician order or facility policy. As a result, the facility failed to maintain complete, accurate, and retrievable clinical records necessary to demonstrate that required skin assessments and monitoring were performed. The facility's failure to retain clinical documentation prevented verification of compliance with physician orders, facility policy, and professional standards of practice.</p>		